Department of State Health Services
Agenda Item for State Health Services Council
January 12-13, 2006

Agenda Item Title: Propose Repeal of 25 TAC, Chapter 39, Subchapter A, Relating to Primary Health Care Services Act Program Rules and New 25 TAC, Chapter 39, Subchapter A, Relating to Primary Health Care Services Program

Agenda Number: 3a

Recommended Council Action:
____For Discussion Only

_X_ For Discussion and Action by the Council

Background: Primary Health Care Services provides access to basic health care services for those individuals residing in Texas with incomes at or below 150% of the Federal Poverty Level who are unable to access the same care through other funding sources or programs.

Summary: The repeal and new sections are proposed in response to the four-year of state agency rules required by Government Code §2001.039, as well as changes in programmatic implementation due to legislation and departmental policy modifications.

Summary of Stakeholder Input to Date (including advisory committees): All Community Health Services contractors and staff were solicited for input via email correspondence, eight regional training meetings around the state, and a conference call. Additionally, a notice was posted on the Primary Health Care web site that included an email address and fax number inviting written comments.

Proposed Motion: Motion to recommend approval for publication of rules as contained in agenda item 3a.

Agenda Item Approved by: Evelyn Delgado	**Date Submitted**
Presented by: _Dr. Cindy Jones_____ **Title**: __Unit Manager_____	12/28/05
Program/Division: _Preventive and Primary Care Unit	
Contact Name/Phone: Kim Roberts, 458-7796, x 2990	

Title 25. HEALTH SERVICES
Part 1. DEPARTMENT OF STATE HEALTH SERVICES
Chapter 39. Primary Health Care Services Program
Subchapter A. **[Texas]** Primary Health Care Services **[Act]** Program **[Rules]**
Repeal §§39.1-39.22
New §§39.1-39.11

PROPOSED PREAMBLE

The Executive Commissioner of the Health and Human Services Commission, on behalf of the Department of State Health Services (department), proposes the repeal of §§39.1-39.22 and new §§39.1-39.11, concerning the provision of primary health care services in this state.

BACKGROUND AND PURPOSE

The repeal and new sections are necessary to comply with Health and Safety Code, Chapter 31, which directs the department to establish a program to provide primary health care services to eligible individuals. The Primary Health Care Services Program provides access to basic health care services for individuals whose incomes do not exceed 150% of the Federal Poverty Level residing in Texas who are unable to access the same care through other funding sources or programs.

Government Code, §2001.039, requires that each state agency review and consider for re-adoption each rule adopted by that agency pursuant to the Government Code, Chapter 2001 (Administrative Procedure Act). Sections 39.1-39.22 have been reviewed, and the department has determined that reasons for adopting the sections continue to exist because rules on this subject are needed.

Since legal, policy, and operational issues have changed significantly since the rules were adopted in 1986, the department determined that review and revision of the subchapter could be accomplished most effectively by proposing the repeal of the existing sections in the subchapter and proposing new language to remove outdated information and replace it with current information in a better-organized manner.

SECTION-BY-SECTION SUMMARY

Section 39.1 introduces the subchapter and states a purpose and mission for the provision of primary health care services as prescribed by Health and Safety Code, Chapter 31.

Health and Safety Code, §31.002, authorizes the department to define terms as necessary to administer the chapter. Section 39.2 defines specific terms used throughout the subchapter that pertain to the delivery of primary health care services by the department.

Health and Safety Code, §31.003 and §31.005, direct the department to adopt rules to guide the effective and efficient provision of services. Section 39.3 includes general requirements for the provision of primary health care services and a prioritization of the types of services that, at a minimum, must be provided to recipients because the department faces budgetary limitations. These fundamental services consist of diagnosis and treatment, emergency services, family planning services, preventive health services, health education, and diagnostic services. The requirements also include criteria, such as geographic area, socioeconomic status and available community resources, to guide where and to whom services should be provided, based upon unmet needs. If the department determines that existing community resources are unavailable or unable to meet the primary health care needs of the population in need, the department may deliver services directly to eligible individuals. Section 39.3 also clarifies that recipients eligible for Medicare Part D must receive prescription drug benefits according to Medicare regulations if the provider offers supplemental prescription drug benefits as part of the department's primary health care program.

As required by Health and Safety Code, §31.004 and §31.006, §39.4 outlines the process and requirements for the provision of contracts to providers that deliver primary health care services. Services may be delivered through a network of providers, directly by the department, or by a combination of both to ensure recipients are able to receive necessary services. The department must contract for services using a Request for Proposals process in accordance with state law and department policy. The department may deny, modify, suspend or terminate provider contracts for cause, and an applicant or current contractor that is aggrieved in relation to the award of a contract may file a protest in accordance with department policy.

Section 39.5 delineates the circumstance in which the department is obligated to reimburse providers for contracted services rendered and the timeframe in which providers can expect to receive payment.

Health and Safety Code, §§31.007-31.008, require the department to adopt rules relating to application procedures and eligibility criteria for potential program recipients. Section 39.6 states an individual must be in financial need and be a Texas resident in order to be eligible for program services. Individuals found ineligible for services may reapply at any time. The section also states that providers are required to assist applicants in completing the application process, provide coverage if the applicant meets eligibility criteria, determine if the applicant is eligible for Medicare Part D coverage, and provide services to potentially-eligible individuals with immediate medical needs. Although providers may collect co-payments from eligible individuals receiving services, no one shall be denied services based on an inability to pay, and pre-treatment deposits and/or payments are prohibited. The section explains that providers that offer supplemental prescription drug coverage as part of their primary health care program may reimburse eligible recipients for co-payments made for medications under Medicare Part D upon availability of funds.

Section 39.7 outlines the criteria necessary to maintain eligibility for program services. Recipients must continue to be in financial need and reside in Texas. Recipients are required to inform their providers of changes in address, health insurance coverage, employment, income, and family composition to ensure continued eligibility for services.

Health and Safety Code, Chapter 31, requires that primary health care services must be provided, to the greatest extent possible, to low-income individuals who are not eligible for similar services through other publicly-funded programs and who do not have another source of support. In order to assure that the department is the payer of last resort, §39.8 mandates coordination of benefits between the department, providers of other benefits programs, and person(s) who have a legal obligation to financially support the recipient.

Section 39.9 describes the terms under which services to recipients and applicants may be denied, modified, suspended, or terminated as required by Health and Safety Code, §31.009. Applicants who intentionally provide false or incomplete information, recipients that are no longer eligible for services, and recipients or other persons who have a legal obligation to support a recipient that do not reimburse the department for services will receive written notice of the denial, modification, suspension, or termination of services and an opportunity for a fair hearing.

Section 39.10 establishes the process by which an appeal requested by a recipient or applicant aggrieved by a program decision to deny, modify, suspend, or terminate participation in program services will be conducted.

According to Health and Safety Code, §31.015, the department is required to adopt rules relating to the information a provider shall report to the department. Section 39.11 states that program review activities will be conducted to ensure the delivery of appropriate services and evaluate the continued need for services. The department will require providers to report on the number of recipients served, demographic information about recipients, fiscal and expenditure information, program accomplishments, and coordination of benefits with other providers.

FISCAL NOTE

Cindy Jones, Ph.D., R.N., Manager, Preventive and Primary Care Unit, has determined that for each year of the first five years the sections are in effect, there will be no fiscal implications to state or local governments as a result of administering the sections as proposed. The new sections are not anticipated to have significant fiscal impact because the proposed rules do not change current program structure and implementation.

SMALL AND MICRO-BUSINESS IMPACT ANALYSIS

Dr. Jones has also determined that there will be no effect on small businesses or micro-businesses required to comply with the sections as proposed, because neither small businesses nor micro-businesses that are providers of primary health care services will be required to alter their business practices in order to comply with the sections. There are no anticipated economic costs to persons who are required to comply with the sections as proposed. There is no anticipated negative impact on local employment.

PUBLIC BENEFIT

Dr. Jones has also determined that for each year of the first five years the sections are in effect, the public benefit anticipated as a result of administering the sections will be continued access to basic health care services for eligible, low-income Texas residents.

REGULATORY ANALYSIS

The department has determined that this proposal is not a "major environmental rule" as defined by Government Code, §2001.0225. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

The department has determined that the proposed sections do not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, do not constitute a taking under Government Code, §2007.043.

PUBLIC COMMENT

Comments on the proposal may be submitted to Kim Roberts, Mail Code 1923, Community Health Services Section, Department of State Health Services, 1100 West 49th Street, Austin, Texas 78756-3189 or by email to kim.roberts@dshs.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Cathy Campbell, certifies that the proposed rules have been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

STATUTORY AUTHORITY

The proposed repeal and new sections are authorized by Health and Safety Code, §31.004 which requires the department to adopt rules necessary to administer the Texas Primary Health Care Services Act; and Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Chapter 1001, Health and Safety Code.

The proposed repeal and new sections affect Health and Safety Code, Chapter 31.

Sections for repeal.

§39.1. Introduction.
§39.2. Definitions.
§39.3. General Program Requirements.
§39.4. Contracts and Written Agreements.
§39.5. Selection of Providers.
§39.6. Matching Share.
§39.7. Eligibility.
§39.8. Determination of Eligibility.
§39.9. Maintaining Eligibility.
§39.10. Co-payment for Primary Health Care Services.
§39.11. Primary Health Care Services Provided.
§39.12. Funds.
§39.13. Coordination of Benefits and Recovery of Costs.
§39.14. Denial/Modification/Suspension/Termination of Services.
§39.15. Payment for Services.
§39.16. Development and Evaluation of Program.
§39.17. Program Review.
§39.18. Appeals.
§39.19. Confidentiality.
§39.20. Gifts.
§39.21. Nondiscrimination.
§39.22. Federal Poverty Income Guidelines.

Legend: (Proposed New Rules)
Regular Print = Proposed new language

§39.1. Introduction.

(a) The purpose of these sections is to establish a system of primary health care services for eligible individuals as prescribed by Health and Safety Code, Chapter 31.

(b) The Department of State Health Services seeks to fund local projects that utilize early intervention and prevention of health problems. These projects will utilize and integrate a plurality of existing primary health care services and providers into a structured service delivery system. Access to appropriate levels of health care can reduce health expenditures, mortality, morbidity, and improve individual productivity, health status, and economic growth.

§39.2. Definitions. The following words and terms, when used in these sections, shall have the following meanings, unless the context clearly indicates otherwise:

(1) Act - The Texas Primary Health Care Services Act, Health and Safety Code, Chapter 31.

(2) Applicant - An individual and/or family applying to receive primary health care services.

(3) Commission - The Texas Health and Human Services Commission.

(4) Commissioner - The Commissioner of Health.

(5) Department - The Department of State Health Services.

(6) Eligible individual - An eligible recipient of primary health care services under the Act.

(7) Other benefit - A benefit, other than a benefit provided under the Act, to which an individual is entitled for payment of the costs of primary health care services, including:

(A) benefits available from

(i) an insurance policy, group health plan, or prepaid medical care plan;

(ii) Title XVIII or Title XIX of the Social Security Act;

(iii) the Veterans Administration;

(iv) the Civilian Health and Medical Program of the Uniformed Services; and

§39.2

(v) workers compensation or any other compulsory employer's insurance program;

(B) a public program created by federal or state law, or by an ordinance or rule of a municipality or political subdivision of the state, except those benefits created by the establishment of a city or county hospital, a joint city-county hospital, a county hospital authority, a hospital district, or by the facilities of a publicly supported medical school; or

(C) benefits resulting from a cause of action for medical, facility, or medical transportation expenses, or a settlement or judgment based on the cause of action, if the expenses are related to the need for services provided by the Act.

(8) Primary health care services – which include the following:

(A) diagnosis and treatment;

(B) emergency services;

(C) family planning services;

(D) preventive health services, including immunizations;

(E) health education;

(F) laboratory, x-ray, nuclear medicine, or other appropriate diagnostic services;

(G) nutrition services;

(H) health screening;

(I) home health care;

(J) dental care;

(K) transportation;

(L) prescription drugs and devices and durable supplies;

(M) environmental health services;

(N) podiatry services; and

(O) social services.

(9) Program - The primary health care services program created by the Act.

§§39.2-39.3

(10) Provider - An entity that, through a grant or a contract with the department, delivers primary health care services that are purchased by the department for the purposes of the Act.

(11) Recipient - An individual receiving primary health care services under the Act.

(12) Request for proposal - A solicitation providing guidance and instructions issued by the department to entities interested in submitting applications to provide primary health care services under the Act.

(13) Services - Primary health care services.

(14) Texas resident - An individual who is physically present within the geographic boundaries of the state, and who:

(A) intends to remain within the state, whether permanently or for an indefinite period;

(B) maintains an abode within the state (i.e., house or apartment, not merely a post office box);

(C) does not claim residency in any other state or country;

(D) is under 18 years of age, and at least one of his/her parents, managing conservator, or guardian is a bona fide resident of Texas;

(E) is a person residing in Texas and his/her legally dependent spouse is a bona fide resident of Texas; or

(F) is an adult residing in Texas whose legal guardian is a bona fide resident of Texas.

§39.3. General Program Requirements.

(a) Because budgetary limitations exist, all program providers shall offer at least the following priority services:

(1) diagnosis and treatment;

(2) emergency services;

(3) family planning services;

(4) preventive health services, including immunizations;

(5) health education; and

§§39.3-39.4

(6) laboratory, x-ray, nuclear medicine, or other appropriate diagnostic services.

(b) The department, through approved providers, shall provide for the delivery of primary health care services to those populations that demonstrate unmet needs due to the inaccessibility and/or unavailability of primary health care services. Unmet needs may be determined by, but are not limited to, the following criteria:

(1) geographic area;

(2) demography;

(3) socioeconomic conditions;

(4) cultural factors affecting the health status;

(5) health problems; and

(6) health resources available in the community.

(c) The department may deliver services directly to eligible individuals if existing private or public providers or other resources in the service area are unavailable or unable to provide those services, as evidenced by the applications received during the Request for Proposals process. The department shall make determinations that providers or resources are unavailable or unable to provide services in accordance with Health and Safety Code, §31.005.

(d) Individuals eligible for prescription drug benefits under Medicare, Part D, who reside in areas of the state served by program providers that offer prescription drugs as a primary health care service shall receive prescription drug benefits according to Medicare regulations and procedures. Individuals who are not eligible for prescription drug benefits under Medicare, Part D, who reside in areas of the state served by program providers that offer prescription drugs as a primary health care service shall receive covered prescription drugs dispensed by pharmacy providers according to this chapter.

§39.4. Provision of Contracts for Primary Health Care Services.

(a) Primary health care services will be delivered through a network of providers, directly by the department, or by the department and providers in combination. Eligible

individuals should receive services as close to their home as possible, except in those situations where providers or policies require treatment at specific facilities.

(b) Services may be limited as to frequency, duration, and cost for budgetary and administrative reasons.

(c) In order to conserve funds and effectively administer the program, the department shall contract on a Request for Proposal basis for primary health care services.

§§39.4-39.6

(d) The department shall publish public notice of Requests for Proposal, release the applications, and select providers in accordance with state law and department policy.

(e) The department may deny, modify, suspend, or terminate the approval of providers for submitting false or fraudulent claims or failing to provide and maintain quality services according to medically acceptable standards. A provider's performance under its contract may subject the provider to review, fraud referral to the appropriate authority, and/or administrative sanctions.

(f) An applicant and/or a current contractor who is aggrieved in connection with the award of a department contract to provide primary health care services may file a protest in accordance with department policy.

§39.5. Provider Reimbursement for Primary Health Care Services.

(a) The department will reimburse providers for services rendered in accordance with the contracts between the providers and the department. The department shall pay only valid claims submitted according to the terms of the providers' contracts.

(b) Except for prescription drugs covered under Medicare, Part D, primary health care providers will be reimbursed for services delivered to presumptively eligible clients.

(c) All payments made on behalf of individuals will be for claims received within 90 days from the date services were delivered.

§39.6. Eligibility Requirements and Provision of Services to Recipients.

(a) Individuals covered under the Act are those who are not eligible for other benefits. Individuals eligible for prescription drug benefits under Medicare, Part D, who reside in areas of the state served by program providers that offer prescription drugs as a primary health care service may be eligible for other program services, and for prescription drugs not covered by Medicare, Part D.

(b) Nothing in this section shall preclude a system of integrated eligibility with the commission.

(c) In order for an individual to be eligible for primary health care services, the individual must:

(1) be in financial need based on a family income that does not exceed 150% of the current Federal Poverty Level guidelines; and

(2) be a Texas resident.

(d) In accordance with program policy, providers:

§§39.6-39.8

(1) shall assist applicants in completing the eligibility screening process and shall provide coverage if the applicant is potentially eligible for program services;

(2) shall determine whether each program participant is eligible for prescription drug benefits under Medicare, Part D;

(3) may collect co-payments from eligible individuals who receive primary health care services; and

(4) shall provide services to potentially eligible individuals who require immediate medical attention on a presumptive eligibility basis.

(e) Subsection (d)(4) of this section notwithstanding, no otherwise eligible individual unable to pay a co-payment may be denied services.

(f) If funds are available, the program may pay co-payments required under federal regulations for eligible individuals receiving prescription drug benefits under Medicare, Part D, if the eligible individual resides in an area of the state served by a program provider that offers prescription drugs as a benefit under the primary health care service program.

(g) No eligible individual or person legally responsible for an eligible individual shall be required to make a pre-treatment payment or deposit.

(h) An individual found ineligible for program services may reapply at any time.

§39.7. Maintaining Eligibility. To maintain eligibility for program benefits, the recipient must continue to reside in Texas, be in financial need as defined by these sections, and inform the provider in writing or by telephone within 14 days of changes in the following:

(1) permanent home address;

(2) health insurance coverage;

(3) employment;

(4) other income, or

(5) family composition.

§39.8. Coordination of Benefits.

(a) An individual is not eligible to receive services delivered under the Act when the individual, or a person with a legal obligation to support the individual, is eligible for some other benefit that would pay for all or part of the services, unless coverage for those services has been denied.

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(b) An individual who applies for or receives primary health care services shall inform the provider at the time of application or at the time the individual receives services of any other benefit to which the individual or person who has a legal obligation to support the individual may be entitled.

(c) An applicant or person who has a legal obligation to support an applicant who has received services that are covered by some other benefit shall reimburse the department to the extent of the services provided when the other benefit is received.

(d) The commissioner, or the manager of the department unit having responsibility for oversight of the primary health care services program, if so authorized by the commissioner, may waive enforcement of this section concerning individual applicants if enforcement of this section would deny services to a class of otherwise eligible individuals because of conflicting federal, state, or local laws or regulations.

§39.9. Denial/Modification/Suspension/Termination of Services.

The department may deny, modify, suspend, or terminate services to an applicant or recipient after written notice and an opportunity for a fair hearing if:

(1) the applicant has provided intentionally false or incomplete information on the application form;

(2) the recipient is no longer eligible; or

(3) reimbursement for a benefit to which the recipient or a person who has a legal obligation to support the recipient is entitled is not provided to the program.

§39.10. Appeals.

(a) A recipient or applicant aggrieved by the denial, modification, suspension or termination of services may appeal the program's decision according to the procedures in §§1.51-1.55 of this title (relating to Fair Hearing Procedures). If an aggrieved recipient requests a hearing, the department shall not terminate services to the recipient until a final decision is rendered.

(b) An applicant or recipient may not appeal a denial, modification, suspension, or termination of program services by the department if the department has restricted program services according to priorities established by §39.3(b) of this title (relating to General Program Requirements) and/or program funds are reduced or curtailed.

(c) Upon a final determination that program benefits will be denied, modified, suspended, or terminated, the department will notify the aggrieved recipient's provider in writing.

§39.11. Program Review.

§39.11

(a) Program review activities will be accomplished through monitoring systems developed to ensure the delivery of appropriate services.

(b) At least annually, the department shall review and determine the continued need for the services it provides directly in accordance with the methods and procedures used to make the initial determination prescribed by the Act and these sections.

(c) The department will require providers to report to the department the following:

(1) demographic information on eligible individuals;

(2) the number of eligible individuals receiving services and the cost of services per individual recipient;

(3) fiscal and financial management reports of expenditures;

(4) program accomplishments;

(5) the number of applicants found ineligible for services; and

(6) networking and coordination of services with other providers.

(d) The department may request other data and/or reports upon prior notification.

Note: The entire Subsection A of Title 25 TAC Chapter 39 is proposed for repeal and replaced with new language. Please find the language to be deleted below.

Legend: (Proposed Repeal of Chapter 39, Subsection A)
[Bold, Print and Brackets] = Current language proposed for deletion

[§39.1 Introduction

(a) The purpose of these sections is to establish a system of primary health care services on eligible individuals as prescribed by House Bill 1844, 69th Legislature, 1985, and the findings of the Indigent Health Care (IHC) Task Force appointed by the governor, lieutenant governor, and speaker of the House of Representatives. The Legislative and IHC Task Force directions include specifications for:

(1) a system of priorities relating to the type of individuals eligible for services;

(2) provision of primary health care services by existing providers;

(3) evaluation and planning based on careful monitoring of service delivery, costs, patient needs, and diagnoses; and

(4) coordination of primary health care services with other Indigent Health Care Legislation programs.

(b) The Primary Health Care Service Program seeks to fund local projects that utilize early prevention and early intervention of health problems. This program will utilize and integrate a plurality of existing primary health care services and providers into a structured service delivery system. Access to appropriate levels of health care can reduce health expenditures, mortality, morbidity, and improve individual productivity, health status, and economic growth.

§39.2 Definitions

The following words and terms, when used in these sections, shall have the following meanings, unless the context clearly indicates otherwise:

(1) Act--The Texas Primary Health Care Services Act, Texas Civil Statutes, Article 4438d (House Bill 1844, 69th Legislature, 1985).

(2) Applicant--An individual applying to receive primary health care services. In determining financial need of the applicant, the income of the applicant's family will be taken into consideration.

(3) Board--The Texas Board of Health.

(4) Commissioner--The commissioner of health.

(5) Council of governments--Regional councils which are voluntary associations of local governments formed under the Regional Planning Act of 1965, Texas Civil Statutes, Article 1011M, §3(a).

(6) Department--The Texas Department of Health.

(7) Eligible individual--An eligible recipient of primary health care services under this Act.

(8) Eligibility date--The actual date the individual submits a completed application to the provider. The eligibility ending date will be 12 months from the beginning date, unless individuals are granted eligibility for a shorter duration due to special circumstances.

(9) Facility--Includes hospitals, ambulatory surgical centers, public health clinics, birthing centers, outpatient clinics, and community health centers.

(10) Family--A group of two or more persons related by birth, marriage, adoption who reside together. All such related persons are considered as members of one family.

(11) Legally responsible person--A parent or another person who is legally responsible for one's self or a minor. (Note: stepparents, grandparents, adult siblings, or aunts and uncles are not legally responsible for minor relatives, unless so designated by a court.)

(12) Medical transportation--Transportation services that are required to obtain appropriate and timely primary health care services for eligible individuals.

(13) Minor--A person who has not reached his/her 18th birthday and who has not had the disabilities of minority removed in court or who is not or never has been married or recognized as an adult by the State of Texas.

(14) Other benefit--A benefit, other than a benefit provided under this Act, to which an individual is entitled for payment of the costs of primary health care services, including:

(A) benefits available under: an insurance policy, group health plan, or prepaid medical care plan; Title XVIII or Title XIX of the Social Security Act; the Veterans Administration; the Civilian Health and Medical Program of the Uniformed Services; and workers compensation or any other compulsory employer's insurance program;

(B) a public program created by federal or state law, or by an ordinance or rule of a municipality or political subdivision of the state, except those benefits

created by the establishment of a city or county hospital, a joint city-county hospital, a county hospital authority, a hospital district, or by the facilities of a publicly supported medical school; or

(C) benefits resulting from a cause of action for medical, facility, or medical transportation expenses, or a settlement or judgement based on the cause of action, if the expenses are related to the need for services provided by this Act.

(15) Person--Includes an individual, corporation, government or governmental subdivision or agency, business trust, partnership, association, or any other legal entity.

(16) Primary Health Care Advisory Committee--An advisory committee appointed by the Board of Health for the purpose of planning and reviewing the development of a comprehensive system of primary health care.

(17) Primary Health Care Services--Referred to as services includes:

(A) diagnosis and treatment;

(B) emergency services;

(C) family planning services;

(D) preventive health services, including immunizations;

(E) health education;

(F) laboratory, x-ray, nuclear medicine, or other appropriate diagnostic services;

(G) nutrition services;

(H) health screening;

(I) home health care;

(J) dental care;

(K) transportation;

(L) prescription drugs and devices and durable supplies;

(M) environmental health services;

(N) podiatry services; and

(O) social services.

(18) Program--The primary health care services program created by this Act.

(19) Provider--A person that, through a grant or a contract with the department, delivers primary health care services that are purchased by the department for the purposes of this Act.

(20) Region--Public health region of the Texas Department of Health.

(21) Request for proposal (RFP)--A solicitation providing guidance and instructions issued by the department to potential providers interested in submitting an application to provide primary health care services through this Act.

(22) Support--The contribution of money or services necessary for a person's maintenance, including food, clothing, shelter, transportation, and health care.

(23) Texas resident--An individual who is physically present within the geographic boundaries of the state, and who:

(A) has an intent to remain within the state, whether permanently or for an indefinite period;

(B) actually maintains an abode within the state (i.e., house or apartment, not merely a post office box);

(C) does not claim residency in any other state or country;

(D) is under 18 years of age and his/her parent(s), managing conservator, or guardian is a bona fide resident of Texas;

(E) is a person residing in Texas and his/her legally dependent spouse is a bona fide resident of Texas; or

(F) is an adult residing in Texas and his/her legal guardian is a bona fide resident of Texas.

§39.3 General Program Requirements

(a) As authorized by the Act, the board, in these sections, has established a Primary Health Care Services Program in the department to provide for the delivery of primary health care services to eligible individuals.

(b) Because budgetary limitations exist, initial service priorities shall focus on the funding of, provision of, and access to the six priority primary health care services listed in paragraphs (1) - (6) of this subsection:

(1) diagnosis and treatment;

(2) emergency services;

(3) family planning services;

(4) preventive health services, including immunizations;

(5) health education; and

(6) laboratory, x-ray, nuclear medicine, or other appropriate diagnostic services.

(c) The department, through an approved provider, shall provide for the delivery of primary health care services to those populations which demonstrate unmet needs due to the inaccessibility and unavailability of primary health care services. Unmet needs may be determined by, but is not limited to, the following criteria:

(1) geographic area;

(2) demography;

(3) socio-economic conditions;

(4) cultural factors affecting the health status;

(5) health problems;

(6) health resources available in community.

(d) The department may deliver services directly to eligible individuals if it is determined that existing private or public providers or other resources in the service area are unavailable or unable to provide those services. In making a determination that providers or resources are unavailable or unable to provide services, the department shall:

(1) initially determine the proposed need for services in the service area;

(2) notify existing private and public providers and other resources in the service area of the department's initial determination of the need for the services and the services the department proposes to deliver directly to eligible individuals;

(3) provide the existing private and public providers and other resources in the service area 30 days to comment on the department's initial determination. After the 30-day comment period, the department will provide the existing private

and public providers and other resources in the service area 30 days to make application as a provider;

(4) approve or disapprove providers after the 30-day application period and within 60 days of a review and comment period;

(5) eliminate, reduce, or otherwise modify the proposed scope or type of services the department proposes to deliver directly under this Act to the extent that those services may be delivered by existing private or public providers or other resources in the service area that meet the criteria for approval.

(e) Individuals eligible for prescription drug benefits under Medicare, Part D, who reside in areas of the state served by program providers that offer prescription drugs as a primary health care service shall receive prescription drug benefits according to Medicare regulations and procedures. Individuals who are not eligible for prescription drug benefits under Medicare, Part D, who reside in areas of the state served by program providers that offer prescription drugs as a primary health care service shall receive covered prescription drugs dispensed by pharmacy providers according to this chapter.

§39.4 Contracts and Written Agreements

(a) In order to conserve funds and effectively administer the program, the department shall contract on a request for proposal basis for primary health care services.

(b) The department shall publish public notice of the request for proposal in the Texas Register at least 30 days prior to the date the application is due. Local published notices or direct contact by the department with potential providers will be utilized.

(c) The department will forward the application packet within 10 working days of receiving a request.

(d) Public health regional staff and Councils of Government will review and comment on proposals.

(e) The primary Health Care Advisory Committee and designated central office staff of the department will review and recommend proposals for funding.

(f) Potential providers submitting proposals will be selected and approved by the department to enter into contracts with the department. Providers that are not selected will receive written notification to that effect from the department within 30 days.

(g) A provider with the department must agree to provide at least the six priority primary health care services, either directly or through agreements or subcontracts with other providers. (See the list described in §39.3(b) of this title (relating to General Program Requirements)).

(h) A potential provider will not be denied approval as a provider on the basis that the potential provider operates for profit or receives federal funds, if those funds are inadequate to meet the needs of all eligible individuals seeking services.

(i) The department may expedite the selection of providers so that primary health care services may be provided to individuals in need on the advice of the Primary Health Care Advisory Committee and the approval of the board or commissioner.

(j) All contracts and written agreements which the department executes are subject to and governed by the requirements in the Uniform Grant and Contract Management Standards adopted by the governor's office in 1 TAC §§5.141-5.167 concerning Uniform Grant and Contract Management Standards.

§39.5 Selection of Providers

(a) The department will make the final selection of providers in the program.

(b) All providers must agree to abide by these sections and to accept program fees as payment for services rendered to eligible individuals.

(c) The department may deny, modify, suspend, or terminate the approval of providers for due cause. Any provider or facility submitting false or fraudulent claims or failing to provide and maintain quality services or medically acceptable standards is subject to review, fraud referral to the appropriate authority, and/or administrative sanctions.

(d) An administrative review and a due process hearing are available to any provider for the resolution of conflicts between the department and the provider in accordance with §39.18 of this title (relating to Appeals).

§39.6 Matching Share

Information regarding matching share, if any, may be found in the request for proposal, which the department has prepared and adopts by reference. Copies are indexed and filed in the Office of the Associateship of Community and Rural Health, Texas Department of Health, 1100 West 49th Street, Austin, Texas 78756, and are available for public inspection during regular working hours.

§39.7 Eligibility

(a) Individuals covered under the Act are those who are not eligible for other benefits. Individuals eligible for prescription drug benefits under Medicare, Part D, who reside in areas of the state served by program providers that offer prescription drugs as a primary health care service may be eligible for other program services offered by Primary Health Care, and for prescription drugs not covered by Medicare, Part D.

(b) Nothing in this section shall preclude a system of integrated eligibility with the Texas Department of Human Services.

(c) In order for an individual to be eligible for primary health care services, the individual must:

(1) be in financial need as defined by these sections; and

(2) be a Texas resident.

(d) Applications are available to anyone seeking assistance from the program. Application forms may be obtained from providers. The completed application form is reviewed by the providers. To be considered, the application must be on forms furnished by the department or forms acceptable to the department which contain information to satisfy the requirements of the rules.

(1) Any documentation requested on the application must be attached to the form or it will be returned as incomplete.

(2) Information required on the application includes, but is not limited to:

(A) the individual's name; present address; date of birth; place of birth; Social Security number, if applicable; and whether the individual is currently eligible for Medicaid or other similar benefits;

(B) the name(s) of individual's dependent(s); present address(es); age(s); whether resident(s) of the state; and Social Security Number(s), if applicable;

(C) health insurance policies providing coverage for the individual; person(s) who is (are) legally responsible for the support of the individual and individual's dependent(s);

(D) income of individual submitting application and spouse's income; and

(E) other benefits available to the family or individual

(e) All providers shall determine whether each program participant is eligible for prescription drug benefits under Medicare, Part D, according to Primary Health Care Services Program policy.

(f) In order to conform to federal and state laws, a minor seeking treatment for communicable diseases or seeking family planning services will be deemed by the department to be emancipated for the purposes of the Act and only the financial resources of the minor will be considered in determining eligibility.

§39.8 Determination of Eligibility

(a) The final determination of eligibility is made by the provider using the information provided in the application. The provider may request verification from any source to establish eligibility. The provider, at a minimum, will require that documentation of income, residency, and dependency be submitted.

(b) The individual's case is considered to be active when all criteria for eligibility have been established. Coverage continues for 12 months, as long as the eligibility criteria continue to be met. Coverage for prescription drug benefits under Medicare, Part D, shall continue as long as the individual remains eligible, according to federal regulations. Individuals who reside in areas of the state served by program providers that offer prescription drugs as a primary health care service may be eligible for prescription drug coverage under the primary health care service program for periods of not more than 12 months if they become ineligible for Medicare, Part D.

(c) Eligibility coverage may be provided for a period less than 12 months in the following circumstances:

(1) an application is pending with another agency for similar benefits and applicant is in need of services; or

(2) applicant has indicated eligibility status may change within 12 months, which may render applicant ineligible.

(d) The provider will respond to the individual in writing within 10 working days after an application is received in completed form. Eligibility status may be determined on the day the completed application is submitted and reviewed, and documentation has been verified.

(e) At the time eligibility is determined and the eligibility beginning date is established and recorded, the expiration date for eligibility will be determined and recorded in the individual's record. An individual will need to be recertified if he/she wants to remain in the program after the eligibility expiration date.

(f) Any questions regarding coverage may be addressed to the provider.

(g) The individual is considered to have filed an application from the time the provider has received a completed application form. Applications will be classified as follows:

(1) denied, if all eligibility requirements are not met;

(2) incomplete, if sufficient information is not provided;

(3) denied, if fraudulent information has been provided; or

(4) approved, if all criteria are met.

(h) Financial need is established on the basis of family income, as follows.

(1) The family income used to determine eligibility is the gross annual income of the applicant and his/her spouse, if applicable.

(2) Gross annual income includes earned wages, pensions or retirement benefits, child support payments received, alimony, unemployment compensation, workers compensation, income from rental properties, or any monies received on a regular basis for family support purposes.

(i) Income guidelines are based on percentages of the current Federal Poverty Income Guidelines and may be adjusted by the department with the consent of the commissioner to meet budgetary limitations. For purposes of determining eligibility for the program, 150% or below of the Federal Poverty Income Guidelines will be followed.

(j) All income of the individual and his/her spouse must be verified in at least one of the following ways:

(1) copy of the most recent paycheck;

(2) copy of the most recent paycheck stub/monthly employee earnings statement;

(3) employer's written verification of gross monthly income;

(4) pension/allotment award letters;

(5) court of domestic relations documentation pertaining to child support;

(6) letter of financial support from person providing support;

(7) unemployment benefits statement or letter from Texas Employment Commission; or

(8) other documents or proof of income determined valid by the provider.

(k) Any other resource available to the eligible individual, or the person who is legally responsible for the support of the individual, must be utilized prior to the use of program funds. This includes benefits from a legal cause of action, settlement, or judgement on behalf of the eligible individual, as well as individual financial resources and third party insurance.

(l) Individuals who are eligible for a portion of benefits from other third party sources may be eligible for supplemental benefits through the Primary Health Care Services Program. Such supplemental benefits are extended only as a source of payment of last resort, when benefits from other sources have been exhausted, or are inadequate to fully cover the costs of medically necessary services.

(m) To be eligible for services under the Act, an individual must not be receiving primary health care benefits which are reimbursable through health insurance, including Medicaid.

(n) An individual must be a bona fide Texas resident.

(o) Verification of Texas residency must be included with the application and may be in the form of a copy of any one of the following:

(1) valid driver's license;

(2) current voter registration;

(3) motor vehicle registration;

(4) rent or utility receipts for one month prior to the month of application;

(5) school records;

(6) Medicaid cards or other similar benefit cards;

(7) property tax receipts; or

(8) other documents or proof of residency if considered valid by the provider.

(p) Verification of an individual's identity shall be in the form of a copy of any one of the following:

(1) valid driver's license;

(2) current voter registration;

(3) current utility bill with name and address noted;

(4) school records;

(5) Medicaid or other similar benefit cards; or

(6) other documents or proof of birth if considered valid by the provider.

(q) Verification of dependency shall be in the form of a copy of one of the following:

(1) birth certificate;

(2) baptismal certificate;

(3) school records; or

(4) other documents or proof of dependency determined valid by the provider.

(r) Supplemental information may be required to establish eligibility if there is incomplete, inadequate, or conflicting information provided by the individual.

(s) The denial of any application to the program will be in writing and will include the reason(s) for such denial. The individual applying for services has the right to an administrative review and a due process hearing as set out in §39.18 of this title (relating to Appeals).

(t) An individual has the right to reapply for program coverage at any time when there is a change of situation or condition.

§39.9 Maintaining Eligibility

To maintain eligibility for program benefits, the individual must continue to reside in the state, be in financial need as defined by these sections and inform the provider in writing or by telephone within 14 days of changes in the following:

(1) permanent home address,

(2) health insurance coverage;

(3) employment;

(4) other income, or

(5) change in family composition.

§39.10 Co-Payment for Primary Health Care Services

(a) Except as provided by subsection (b) of this section, all eligible individuals receiving services shall participate in the payment for primary health care services as rendered and according to the following income guidelines.

(1) Eligible individuals whose annual gross family income is below 100% of the Federal Poverty Income Guidelines may be charged a nominal fee for services

rendered in accordance with their income and approved by the department in the contracting process.

(2) Eligible individuals whose annual gross family income is between 100% and 150% of the Federal Poverty Income Guidelines will be charged a co-payment on a sliding fee basis as determined by the provider and in accordance with the contract provisions.

(b) Upon availability of funds, the program may pay co-payments required under federal regulations for individuals receiving prescription drug benefits under Medicare, Part D, if the eligible individual resides in an area of the state served by a program provider that offers prescription drugs as a benefit under the primary health care service program.

(c) Notwithstanding the provisions of subsection (a)(1) and (2) of this section, an eligible individual may not be denied services because of inability to pay.

(d) Fees collected by the provider shall be retained by the provider and shall be accounted for and expended only for primary health care services in accordance with the Uniform Grant and Contract Management Standards adopted by the Governor's office in 1 TAC, §§5.141 - 5.167, concerning Uniform Grant and Contract Management Standards.

(e) Individuals whose family incomes exceed 150% of the Federal Poverty Income Guidelines will not be eligible for the primary health care services provided by this program.

§39.11 Primary Health Care Services Provided

(a) Primary health care services will be delivered through a single provider, a network of providers, directly by the department, or by a combination of the department and providers. Eligible individuals should receive services as close to their home as possible, except in those situations where providers or policies require treatment at specific facilities.

(b) Services may be limited as to frequency, duration, and cost for budgetary and administrative reasons.

(c) Potentially eligible individuals who require health services may receive them on a one-time-basis and the following criteria will be followed.

(1) Within 30 days, following the delivery of services, the recipient must submit a completed application to the provider and eligibility determination shall be established.

(2) Should the individual(s) be determined to be ineligible for participation in the program, referrals will be made for the delivery of other appropriate health services.

(d) Except for prescription drugs covered under Medicare, Part D, primary health care providers will be reimbursed for services delivered on a one-time-basis. "One-time-basis" is defined as one continuing episode of care which may include several visits as determined necessary by the provider. The department will require the following specific information prior to reimbursement for services provided on a one-time-basis:

(1) diagnosis;

(2) services performed;

(3) name and address of provider; and

(4) name, current address, and date of birth of recipient.

§39.12 Funds

The board may seek, receive, and expend any funds received through an appropriation, grant, donation, or reimbursement from any public or private source to administer the Act, except as provided by other law.

§39.13 Coordination of Benefits and Recovery of Costs

(a) An individual is not eligible to receive services delivered under the Act when the individual or a person with a legal obligation to support the individual is eligible for some other benefit that would pay for all or part of the services, unless those services are denied.

(b) An individual who applies for or receives services delivered under this Act shall inform the provider at the time of application or at the time the individual receives services of any other benefit to which the individual or person who has a legal obligation to support the individual may be entitled.

(c) An applicant or person who has a legal obligation to support an applicant who has received services that are covered by some other benefit shall reimburse the department to the extent of the services provided when the other benefit is received.

(d) The commissioner may waive enforcement as prescribed in these subsections in certain individually considered cases in which enforcement of this section will deny services to a class of otherwise eligible individuals because of conflicting federal, state, or local laws or regulations.

(e) The department may recover the cost of services delivered under this Act from an individual who does not reimburse the department as required or from any third party

who has a legal obligation to pay other benefits and to whom notice of the department's interest has been given.

(f) At the request of the commissioner, the attorney general may bring suit in the appropriate court of Travis County on behalf of the department. The court may award attorney's fees, court costs, and interest accruing from the date on which the department delivered the service to the date the department is reimbursed in a judgement in favor of the department.

§39.14 Denial/Modification/Suspension/Termination of Services

(a) The department may, for cause, deny, modify, suspend, or terminate services to an applicant or recipient after written notice, an opportunity for an administrative review, and an opportunity for a due process hearing have been given to the applicant or recipient.

(b) Any individual requesting or receiving program benefits must be notified in writing that such benefits will be denied, modified, suspended, or terminated if:

(1) the application information is erroneous or falsified;

(2) the individual is no longer eligible;

(3) obligated reimbursement to the program is not provided;

(4) program funds are reduced or curtailed.

(c) The department shall conduct administrative reviews and due process hearings in accordance with §39.18 of this title (relating to Appeals).

(d) The notice and hearing procedures contained in §39.18 of this title (relating to Appeals) do not apply if the department restricts program services to conform to budgetary limitations that require the board to establish service priorities relating to the types of services provided.

§39.15 Payment for Services

(a) Reimbursement for services delivered through the Primary Health Care Services Program will be contingent upon a valid signed contract between the provider and the department.

(b) An eligible individual or person legally responsible for the eligible individual will not be required to make a pre-treatment payment or deposit.

(c) The department will reimburse the provider for services rendered in accordance with the written agreement which exists between the provider and the department. The department will only be obligated to pay those funds as specified in the written agreement.

(d) All payments made on behalf of an individual will be for claims received within 90 days from the date services were delivered.

(e) Requests for payment will either be paid or denied within 60 days of receipt by the department.

(f) The department will require documentation of the delivery of services by the provider, as follows.

(1) Requests for payment will be denied if they are incomplete, submitted on an improper form, contain inaccurate information, or are not submitted within 90 days from the date services were delivered.

(2) Requests for payment which have been denied must be resubmitted in correct form within 30 days from the notice of denial or within the initial 90-day filing deadline, whichever is later.

(3) Corrections must be made on the original request for payment form if at all possible, and a copy of the denial notice must accompany the resubmitted request for payment.

(4) If a new request is submitted, the original request must accompany the new request for payment form.

(5) Additional services will not be considered for payment on a resubmitted request for payment form.

(g) Overpayments made on behalf of eligible individuals to providers must be reimbursed to the department by lump sum payment or, at the department's discretion, deducted from current claims due to be paid to the provider. The opportunity for an administrative review and a due process hearing are available for the resolution of conflicts between the department and a provider in accordance with §39.18 of this title (relating to Appeals).

(h) The department may suspend or cancel payment for services provided if false or fraudulent requests for payments are submitted by a provider.

(i) A contract may not be terminated during the pendency of a due process hearing. Payments due to be paid to providers may be withheld during the pendency of a hearing, and payments shall resume if the final determination is in favor of the Provider.

(j) Any provider failing to provide services according to medically acceptable standards is subject to review, fraud referral to the appropriate authority, and/or administrative sanctions.

§39.16 Development and Evaluation of Program

(a) The Board shall appoint a 12-member statewide advisory committee.

(b) The advisory committee is created for the purpose of advising and assisting the Texas Board of Health and the Texas Department of Health in planning and administering the development of a comprehensive system of primary care. Committee responsibilities will include:

(1) evaluating existing services and unmet needs in developing primary health care networks;

(2) reviewing project applications targeted at high need areas that encourage systematic and coordinated health delivery systems;

(3) reviewing the primary care plan(s);

(4) evaluating ongoing program efforts;

(5) defining both short-range and long-range goals and objectives for the Primary Care Program; and

(6) developing review criteria and standards for Primary Care Program implementation.

(c) The board may appoint any necessary areawide advisory committees to advise the department in planning and conducting the program.

§39.17 Program Review

(a) Program review activities will be accomplished through monitoring systems developed to ensure the delivery of appropriate services.

(b) For economies of scale, and with the consent of the commissioner, the program may contract for concurrent or retrospective program reviews.

(c) The department will establish a program review system to evaluate the delivery of primary health care services. The program review system will allow for technical assistance to the providers.

(d) The department shall maintain a continuing review of the services it provides directly to the individuals who participate in the program.

(e) At least annually, the department shall review and determine the continued need for the services it provides directly in accordance with the methods and procedures used to make the initial determination prescribed by the Act and these sections.

(f) If, after a review, the board determines that a private or public provider or other resource that meets the criteria for approval as a provider is available to provide services, has applied for approval as a provider, and has been approved as a provider, the department shall, immediately after approving the provider, eliminate, reduce, or modify the scope and type of services the department delivers directly to the extent the private or public provider or other resource is available and able to provide the service.

(g) The department will require providers to report to the department the following:

(1) demographic information on eligible individuals;

(2) the number of eligible individuals receiving services and costs per recipient of service;

(3) referral patterns, i.e., number of eligible individuals referred for hospital care;

(4) fiscal and financial management reports of expenditures;

(5) program accomplishments;

(6) an annual report on applicants ineligible for services; and

(7) a report on the networking and coordination of services with other providers.

(h) Other health related data may be required by the department; however, the provider will be given 60 days advance notice prior to the end of the funding cycle.

(i) The department shall annually prepare a report for submission to the governor and the legislature relating to the status of the program. The report shall be available to the general public and must include:

(1) the unduplicated number of patients receiving care under the program;

(2) the total cost of the program, including a delineation of the total administrative cost of the program and the total cost for each service authorized under the program;

(3) the average cost per recipient of services;

(4) the number of recipients of services who received services in each public health region; and

(5) any other information that may be required by the board.

(j) The department will cooperate with federal, state, and local public agencies, and with private agencies and individuals interested in health care of indigents. The department will make every effort to establish cooperative agreements with other state agencies to define respective responsibilities so as to avoid duplication of services.

§39.18 Appeals

(a) Any person aggrieved by a program decision to deny, modify, suspend, or terminate benefits or participation rights may appeal the decision as prescribed in this section.

(b) Within 10 working days after receiving notice of denial, modification, suspension, or termination of benefits or participation rights, an aggrieved person desiring an administrative review shall notify the department by regular mail of his/her request for such review. Additional information bearing on the decision may be submitted at this time. Failure to request an administrative review within the 10-day period is deemed to be a waiver of such review.

(c) Upon receipt of the request, a department administrative review team will affirm or reverse the decision and notify the aggrieved person in writing, giving the reason(s) for their determination.

(d) Within 10 days after receiving written notice of the administrative review team's determination, the aggrieved person may request a due process hearing from the department. A request for a hearing shall be sent to the department by regular mail. Failure to request a hearing within the 10-day period is deemed to be a waiver of the due process hearing and the proposed action shall be taken.

(e) In the event that an aggrieved person does not request an administrative review, the aggrieved person may request a due process hearing from the department within 10 working days after receiving notice of denial, modification, suspension, or termination of benefits or participation rights. A request for a hearing shall be sent to the department by regular mail. Failure to request a hearing within the 10-day period is deemed to be a waiver of the hearing and the proposed action shall be taken.

(f) The date, time, and place of each due process hearing will be determined by the department.

(g) The hearing will not be conducted under the contested case provisions of the Administrative Procedure and Texas Register Act, Texas Civil Statutes, Article 6252-13a, §§12-20, but will include the following:

(1) timely written notice to the aggrieved person of the matters asserted;

(2) an opportunity for the aggrieved person to appear before a hearing examiner to relate his/her position;

(3) an opportunity for the aggrieved person to be represented by counsel or another representative;

(4) an opportunity for the aggrieved person or representative(s) to be heard in person, to call witnesses, and to present documentary evidence;

(5) an opportunity for the aggrieved person to cross-examine witnesses;

(6) a written recommendation by the hearing examiner to the Commissioner setting forth the reasons for the recommendation and the evidence upon which the decision is based; and

(7) a final written decision to be made by the commissioner.

(h) Upon a final determination that program benefits will be denied, modified, suspended, or terminated, the aggrieved person's provider will be notified in writing by the department.

§39.19 Confidentiality

All medical records and other information maintained by the department which is confidential by law shall not be disclosed to the public.

§39.20 Gifts

The department may receive gifts and donations on behalf of the program, which will be deposited in the State Treasury and reappropriated to the program.

§39.21 Nondiscrimination

The Texas Department of Health operates in compliance with Civil Rights Act of 1964, Public Law 88-352, Title VI, 45 Code of Federal Regulations, Part 80, so that no person will be excluded from participation, or otherwise subjected to discrimination on the grounds of race, color, national origin, or handicapping conditions.

§39.22 Federal Poverty Income Guidelines

The department adopts by reference the Federal Poverty Income Guidelines set out in these sections. A copy of the guidelines is indexed and filed at the Associateship of Community and Rural Health, Texas Department of Health, 1100 West 49th Street, Austin, Texas 78756, and is available for public inspection during regular working hours.]

Attachment 4

Health and Human Services Enterprise

Rulemaking Fiscal Impact

June 2005

Agency Unit/Section/Division Department of State Health Services/Division for Family and Community Health/Community Health Services Section	Council Meeting Date January 12-13, 2006
Agency Program Contact Kim Roberts	Telephone No. 458-7796
Rule Topic Primary Health Care Services	

1. Rule Summary.

(Briefly summarize the rule change and why the rule may or may not have fiscal implications.)

A mandatory review in accordance with Government Code, §2001.039 was conducted. Revisions are necessary to reflect changes in programmatic implementation due to legislation and departmental policy modifications. The extensiveness of the revisions made it practical to repeal the chapter and propose new language. The new sections are not anticipated to be controversial or have significant fiscal impact because the proposed rules do not change current program structure and implementation.

2. Fiscal Impact.

Does the rule have foreseeable fiscal implications to either costs or revenues of state government for the first five years the rule is in effect?

☐ **Yes** ☒ **No** If yes, complete the following:

(a) If there are estimated additional costs to the department, explain (1) what new responsibilities will be required; (2) what additional staff will be needed (numbers and classifications); and (3) what other expenses, such as capital or professional services, will be required. Explain any key assumptions that will be needed to reach the figures in the chart in 2(d).

(b) If there is an estimated reduction in costs, explain how the reductions will be accomplished.

(c) If there is an estimated increase in revenue, describe the source and amount. If there is an estimated loss of revenue, describe the source and amount.

Note: Staff may provide the information in (d) on a separate spreadsheet. If spreadsheet is attached, please check here: ☐

(d)

	1. Fiscal Year 20__	2. Fiscal Year 20__	3. Fiscal Year 20__	4. Fiscal Year 20__	5. Fiscal Year 20__
Estimated Additional/Reduction in Cost (specify reduction in parenthesis)					
STATE FUNDS					
FEDERAL FUNDS					
OTHER FUNDS					
TOTAL:					
Estimated Increase/Loss of Revenue (specify loss in parenthesis)					
STATE FUNDS					

FEDERAL FUNDS					
OTHER FUNDS					
TOTAL:					

3. Local Government Impact.

Does the rule have foreseeable positive or negative fiscal implications to either costs or revenues of local governments for the first five years the rule is in effect?

☐ **Yes** ☒ **No** If yes, enter the amounts for each of the five years and explain key assumptions you used to reach the figures.

4. Small Businesses or Micro-Businesses Impact.

Does the rule have ANY adverse economic effect on small businesses or micro-businesses* (regardless of whether it will have an adverse effect on businesses in general)?

☐ **Yes** ☒ **No** If **yes**, complete **4B–E**. If **no**, complete **4A**.

* A small business is a legal entity, including a corporation, partnership, or sole proprietorship, that is formed for the purpose of making a profit, is independently owned and operated, and has fewer than 100 employees OR less than $1,000,000 in annual gross receipts.

A micro-business is a legal entity, including a corporation, partnership, or sole proprietorship, that is formed for the purpose of making a profit, is independently owned and operated, and has 20 or fewer employees.

A. If the rule **will not** have an adverse economic effect on either small businesses or micro-businesses, or both, explain why there will be no adverse effect on one or both.

Primary Health Care Services currently do not have an adverse economic effect on small businesses or micro-businesses under current rules. The new sections will not have adverse economic effect because the proposed rules do not change current program structure and implementation.

Complete (B)-(E) if rule will have an adverse economic effect on small businesses or micro-businesses or both.

Note: You must discuss both small businesses and micro-businesses in your analysis regardless of whether the rule will have an adverse economic effect on either one or both.

B. Explain why there will be an adverse economic effect, such as new fees, reduced revenues, or new regulatory requirements that will increase the cost of doing business.

C. Give an analysis of the cost to small businesses or micro-businesses of complying with the rule. Explain what assumptions you used to calculate these projected costs (for example, a survey of randomly selected assisted living facilities).

D. Compare the cost to small businesses or micro-businesses of complying with the rule with the cost to the largest businesses affected by the rule, analyzing, when possible:

- cost per employee,
- cost per hour of labor, or
- cost per each $100 of sales.

E. Give an analysis of whether it is legal and feasible to reduce the economic effect of the rule on small businesses or micro-businesses, while still accomplishing the intent of the state or federal law being implemented with the rule.

5. Other Cost Impacts.

If there will be costs to persons who must comply with this rule change, other than costs identified in preceding sections, enter estimated costs for the first five fiscal years of implementation:

FY 1	FY 2	FY 3	FY 4	FY 5
N/A	N/A	N/A	N/A	N/A

Explain assumptions used to arrive at these costs.

6. Fiscal Impact on Local Employment:

☒ Rule **will not** have an impact.

☐ Rule **will** have an impact. You must complete an Economic Impact Request and submit it to TWC at least 30 days before the Council meeting.

7. Takings Impact Assessment.

Does the proposed rule create a burden on private "real property" (i.e. real estate or the buildings and other structures attached to real estate)?

☐ **Yes** ☒ **No** If **yes**, contact Legal **immediately** to determine if you are required to complete a Takings Impact Assessment.

Approvals

Signature – Budget Analyst (original signature on file)	Date	Telephone No.
Signature – Budget Director (original signature on file)	Date	Telephone No.
Signature – Chief Financial Officer (original signature on file)	Date	Telephone No.
Signature – Deputy Executive Commissioner (as appropriate) (original signature on file)	Date	Telephone No.